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A PLEA FOR PROMPT INTERFERENCE IN ABDOMINAL DISEASES.[1]

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"Surgery becomes conservative when it tends to alleviate suffering without resorting to operative interference." "An element weakened by disease works viciously, it is true, or perhaps not at all; but if we seek to restore it to normal, we should not eliminate it altogether, but endeavor to heal the trouble, and thus restore the element to at least a measure of healthy action." "Carried into effect without exact diagnosis, and before the merits of a more conservative plan have been tried . . . it becomes a dangerous procedure, if not absolutely criminal." Such expressions are not of unfrequent occurrence in our medical literature. By the side of this, and in contrast to it, allow me to place with equal clearness, my own convictions. When an element weakened by disease, works viciously or not at all, and by so doing renders a patient's life miserable or eventually threatens that life

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itself, the man who stays his hand from eliminating that element, provided it can be done with reasonable safety, and rests satisfied merely with "a measure of healthy action," is, to say the least, not doing his whole duty to his patient. There are many cases of disease, calling for surgical interference, which threaten life, in which an attempt at an exact diagnosis or a trial of the merits of a more conservative plan of treatment becomes, with our present surgical knowledge, not only dangerous but almost, if not entirely, unjustifiable. Statements as strong as these must needs be qualified, that they may not be misunderstood; but it is equally necessary also to qualify such statements as those made in the interests of so-called conservative surgery. No one can appreciate the need of true conservative surgery more than myself, nor the importance of men being thoroughly instructed and trained in the rudiments of our science; but this cry of conservative surgery is too often set up as a mere cloak of ignorance and cowardice. Our sins of omission are oftener greater than our sins of commission.

M. M.; æt. 17; single; family history good; had been in perfect health until present attack. Without any apparent cause she was seized with a pain in the abdomen, which increased rapidly in violence She was seen the second day of the attack; belly tympanitic and swollen; much colicky pain in abdomen; pulse rapid; and some

slight elevation of temperature; anxious expression of face; constipation for several days. Rectal enemata and other appropriate treatment were ordered. From unavoidable delay, the nurse did not give enema until next day. At noon a large solid passage followed the enema, and all the abdominal symptoms became better. Toward night vomiting, which had a suspicious smell, occurred. The patient was now made to drink large quantities of hot water and then vomit it. This gave great relief, and all the symptoms subsided, so much so, that for a second time operative interference was postponed. In the meanwhile the bowels could not be made to act again. Operation was decided on if the bowels did not again move, or if vomiting returned. During the next day the patient was remarkably bright, and in the afternoon ate largely and very greedily of corn-starch, enjoying it very much and retaining it all. Later she rose from her bed and emptied a pint vessel of the same food, retaining and enjoying it. She was apparently better in every way, and an operation was now thought to be unnecessary. Although the bowels had not been opened she said she felt as if they would be at any moment. It was presumed that, by the next day, she would be well over her troubles. At six o'clock in the morning she vomited two or three times, and then suddenly died. The autopsy disclosed a strangulation of the small intestine near the

cæcum, by a band. A single snip of the scissors would have relieved it, and the patient would have been saved.

Here we have a picture which all of us have seen only too many times, and in the vast majority of cases we have seen it end in death. A case of intestinal obstruction is one of such a character that there is little room for hesitation. The disease is caused by such a variety of factors, and is so fatal in its ending, that to waste valuable time attempting an exact diagnosis or going beyond certain limits in the trial of the merits of a so-called conservative plan of treatment, is folly. Lusk never spoke truer words than when he said: "The resources of surgery are rarely successful when practiced on the dying." Why, with our past experience in these diseases, we should continue in the old beaten track of hoping against hope, only to see one valuable life after another slip through our fingers, without an effort to save them, I cannot comprehend. Mr. Treves states that in England, from this disease alone, over two thousand individuals die every year; and I think we are all agreed that in the United States we are equally unfortunate. Surely with such a frightful mortality as this staring us in the face, there can be little use for so-called conservatism. Here, at least, if this tremendous death rate is to be stopped, our only hope lies in bold, aggressive surgery. If a loop of intestine be caught under an

adhesive band and strangulated, where one case may be relieved by purely medicinal treatment, ninety-nine will succumb. Of course, all cases of intestinal obstruction are not due to bands, intussusceptions and such causes; some are simply the result of fecal impaction, a slight temporary paralysis of the gut or some other cause amenable to medicinal treatment. If we knew that these were the causes, then it would be eminently right to persist for a considerable time in proper medical treatment. But this is just the point—we never know, or are never sure of the cause. The organic causes are so vastly in the majority, and the symptoms of all varieties are so much alike, that it is only safe to act always on the assumption that all are serious. Should a mistake be made, and an abdomen be opened for a case of obstruction due, for instance, to a fecal impaction, it would be a cause of regret that an unnecessary step had been taken. But our compensation would be even greater in such a case as this, than would be our chagrin. The diagnosis of an obscure and apparently dangerous case would be cleared up, and we could then proceed with confidence and certainty in our treatment, to a final cure. The harm done would be absolutely nothing. Such a mistake would however seldom be made and the number of curable cases, otherwise necessarily fatal, which would be reached and saved would over and over again triumphantly justify such procedures.

In the case cited above, the indications should have induced an early operation. The symptom of suspicious vomiting alone should have been sufficient to have settled the question; and so it would have done, had not a passage of the bowels been obtained. From this point on, everything was in a position of uncertainty, and the old adage: "He who hesitates is lost," was again exemplified. The feces obtained were, of course, what was impacted below the seat of the obstruction, and that having come away, there was no more to follow. Fecal vomiting should always and invariably be taken as the limit of waiting in these cases. This having occurred once, opportunity should not be given for it to happen a second time, no difference what the other symptoms may be. It will be the rarest exception in the world that a mistake will be found to have been made. If relief has not been obtained within twenty-four hours by means of persistent and gently applied rectal enemata, the abdomen should always be laid open and explored, and whatever is found properly treated.

Two cases have recently come under my notice. Both were operated on after considerable delay, and, when the operation was finally done, a single stroke of the knife ended the strangulation and freed the bowel. In both cases several good passages occurred *per rectum* before the death of the patients. Both died from simple exhaustion. Here

are three cases within a very short while, in all of which the subjects should be alive to-day, all young women and holding valuable places in the community. I could go back through the past three or four years of my experience and recall a dozen or more such examples, all of whom died for want of an early operation. The mortality of laparotomy for these diseases has been and is large—most frightfully so. Treves has collected 122 cases, with a mortality of over 63 per cent. According to Schramm the mortality in 193 collected laparotomies for intestinal obstruction is over 65 per cent. "Some of the patients were almost moribund at the time the laparotomy was performed, others were in a condition of profound exhaustion. In some there was general acute peritonitis, in others fecal extravasation had already taken place. Laparotomy has, indeed, been looked upon as a last resource instead of as a primary measure. This table shows in a graphic manner how serious is the delay, even of twenty-four hours" (Treves). An examination of the records shows very clearly that in cases in which the operation has been undertaken early enough, it is not a very dangerous one. In fact to those familiar with the present status of abdominal surgery, a simple incision into the abdominal cavity is a comparatively trifling measure. The great and only danger comes from delaying until the individual is past recovery.

These remarks as in regard to intestinal obstruction are equally true when applied to any other disease occurring in the peritoneal cavity. In a list of laparotomies collected by myself more than a year ago, there were 93 operations done for non-malignant diseases. Of these, eleven were followed by death. Of the eleven deaths—all after simple exploratory incisions—seven occurred for no other reason than that the operation was undertaken too late and the patient was in a dying condition. All the patients could have been saved had they been taken in hand in time. This element of time is being more generally recognized as of the utmost importance. We now accept it as one of the primary requisites in the Cæsarean section, and it is undoubtedly the one element which has chiefly contributed to raise that operation to its present successful status. If this be of such vital importance in the Cæsarean section, it is none the less so in cases of intra-peritoneal diseases. We daily see cases die shortly after an operation which should almost certainly have recovered.

Mrs. P., after an operation for an ovarian cyst, developed a purulent peritonitis. The case was temporized with day after day, because she became at times better and seemed on the way to recovery, in spite of the fact that the presence of pus was strongly suspected. She struggled on for three or four weeks, or more, and was finally given

the benefit of an operation. Pus was found in large quantities. She made a brave fight for six days, and then died of exhaustion and sepsis. An operation one week earlier would undoubtedly have saved her.

X., medical student, was suddenly attacked with pain in his stomach and retired to bed. From the first there was well marked and exaggerated symptoms of peritoneal inflammation in the region of the cæcum. He was temporized with for four days, and was fed on morphia to ease his pain, with other so-called conservative treatment. He was told that there was not much the matter with him, and that he would get well. The attendant had seen many worse cases recover. A surgeon saw the patient the next day, and immediately operated. An ileo-cæcal abscess, with a badly diseased appendix vermiformis, was found. The patient died the same night.

Mrs. R. suffered for seven or eight years with pelvic trouble, being treated conservatively (?) all the time. Suddenly she developed acute symptoms of intestinal obstruction. So-called conservative treatment was renewed. The patient went into collapse and an operation was advised. The consultant physician objected. The patient recovered from her collapsed condition, and in twenty-four hours had a similar attack. An operation was even yet opposed. The patient made a partial recovery from this second collapse, only to fall into the same

condition for a third time. At this late hour an operation was agreed upon, and disclosed large pus tubes, with intestines so tightly bound upon them as to strangulate them. Death followed in twenty-four hours.

Miss L., suffering plainly referable to calculus, and a large stone, immovably fixed in one of the ureters, plainly felt by vaginal examination. Whole cause of trouble clearly recognized and the impossibility of spontaneous delivery realized. Patient in good condition and willing for anything to gain relief. Allowed to drift on under hopeless conservatism until operation was impossible.

Mrs. C., clear history and diagnosis of extra-uterine pregnancy, with rupture of the gestation sac. Condition of patient fully realized and yet temporized with. Operation after two days delay, and, naturally enough, death followed from exhaustion.

But why should I cite more illustrations? You have all seen them and fully realize the truth of the statement that where one individual is killed by an unnecessary operation, hundreds die for want of one. An exploratory operation, with the patient in good condition, is a very harmless thing; and those of us in future, who allow patients to die from well marked intra-abdominal disease and stand in the way of an operation, can no longer hide our want of skill and knowledge under this false cry of conserv-

atism. Bantock and Price have both entered strong pleas for early interference, especially in ovarian tumors. It is folly to wait "until the heart and lungs, digestive organs, kidneys, bladder and rectum, no longer discharge their functions without disturbance," or "until the general health has become impaired," or "until all other means of relief have failed, and the patient's health is giving way under the extension of the disease," or "until the patient is failing in strength and becoming emaciated, depressed and nervous," as advised by many prominent men and teachers. In the words of Bantock, I am not aware that there is any operation in the whole range of surgery, in any other part of the body, *that must be a matter of necessity sooner or later,* if the patient's life is to be saved, in which it is considered advisable to await this contingency. Many cases are being refused for operation by operators, because of their having been left so late and handled by a more conservative plan of treatment until it is too late for surgery to have even a half chance of success.

I have in my practice at the present time half a dozen women, all of whom have run the gauntlet of the dangers of peritonitis two or more times and have come out of each attack in a much worse condition than they were before. They all refuse operative interference because they know, or have been told of, some friend who has died after an opera-

tion. Of these deaths, two to my personal knowledge were hopeless cases and should never have been touched with the knife. The consequence of the conservative treatment which had encouraged them on to death, with pus tubes in their abdomens, is that a dozen or more women are gradually dying for want of proper treatment. When a patient is dying it is simply a blow to good surgery to attempt any operation whatever.

In the words of one of Philadelphia's most brilliant gynæcologists: "The day is coming when Abdominal Surgeons will be the most arbitrary of men and will refuse to interfere, when called in only at the eleventh hour, merely as a last resource." If surgery has any place in intra-abdominal diseases it most emphatically is not as a last resource, but as a primary measure. As a last resource, abdominal surgery, the world over, has proven a dismal failure; as an early and primary procedure, there is no branch of our art which has achieved such brilliant and lasting results.

We have only to look at the records of the prominent gynecologists, to see who have, and who have not, accepted this principle of early and timely interference. It is unnecessary to go beyond this city to find such a man, one whose work has made him an ornament to our profession; and Dr. R. S. Sutton can rest well content that, in his last thirty abdominal sections, for various diseases, he has saved every one of his patients.

As an end of this short and imperfect plea for the necessity of prompt and intelligent work in abdominal diseases, I cannot do better than quote the words of Dr. John B. Roberts, in his address to the Philadelphia Academy of Surgery, 1888: "Above all, the successful surgeon is a man of action. Experience and knowledge must be there, but they are of little value without action. Inexperience and ignorance are the parents of timidity and recklessness. To avoid these dangers he must have experience and knowledge, which though power, are mere possibilities until used as a source of deeds. The victory of battle is to the leader who does most, not to him who knows most. The true surgeon often takes the offensive, which is for the intrepid alone; but the weak surgeon falters and lets death come because of his offensive hesitancy."